

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00632

Reg. Dist. No.

670

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland		b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Jefferson		c. LENGTH OF STAY IN 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Jefferson		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Lester	Middle R.	4. DATE OF DEATH Ahalt	Month 1	Day 24	Year 1958			
5. SEX male	6. COLOR OR RACE w hite	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/1879	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner			10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Mathis Ahalt			14. MOTHER'S MAIDEN NAME Martha Sheffer			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Dorsey Ahalt, Jefferson, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 430.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO with Trigard (c) DUE TO Coronary Occlusion Coronary Sclerosis						INTERVAL BETWEEN ONSET AND DEATH 1 mo			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Middleton	(County) Middlesex	(State) N.J.	
21. I certify that I attended the deceased from 1/24/1958 to 1/24/1958 , that I last saw the deceased alive on 1/17/1958 , and that death occurred at 8 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Middleton, Md.			DATE SIGNED 1/24/1958
ACTUAL SIGNATURE A. T. BRICE		PHYSICIAN'S NAME (Type) A. T. BRICE							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/27/1958		22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		22d. LOCATION (City, town, or county) Middleton, Md.		(State) N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 28 '58		24b. REGISTRAR'S SIGNATURE Alfred E. Johnson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. It should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY		FREDERICK	
FREDERICK							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
RURAL and give nearest town)				NEW MARKET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
FREDERICK				NEW MARKET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
FREDERICK MEMORIAL HOSPITAL							
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
POSIE		M.	BAKER	JAN	27	1958	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	MAR 14-1887	70			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		HOME		MARYLAND		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
JOHN MOUNT		SUSAN WALTS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
✓				MARY STOTTLER		342 PARK AVE FREDERICK MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of cerebral Artery							
DUE TO							
332X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.							
(b) Arterio sclerosis							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Arterio sclerotic heart disease							
INTERVAL BETWEEN ONSET AND DEATH 14 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 1956, to Jan. 27, 1958, that I last saw the deceased alive on Jan 26, 1958, and that death occurred at 2:45 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)				DATE SIGNED	
Ralph L. Michels							
PHYSICIAN'S NAME (Type)		Ralph L. Michels		New Market, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)	
BURIAL		JAN 30-58		NEW MARKET CEMETERY		NEW MARKET MD	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
W. E. Johnson		New Market Md		FEB 3 '58		A. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use of the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00634

Reg. Dist. No.

637

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 308 West Patrick St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rose	Middle Marie	Last Beall	4. DATE OF DEATH	Month Jan.	Day 3	Year 1958
S. SEX Female	6. COLOR OR RACE White	7. MARRIAGE STATUS WIDOWED	8. B. DATE OF BIRTH Sept. 12-1898	9. AGE (in years lost birthday) 59	10. IF UNDER 1 YEAR Months 59	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Historical Museum		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Hopp				14. MOTHER'S MAIDEN NAME Catherine ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-12-2469		17. INFORMANT Mr. Francis A. Beall - 373 W. 5th St.-Frederick		Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490 X DUE TO Lobar pneumonia, bilateral, etiology undetermined. INTERVAL BETWEEN ONSET AND DEATH 1 week.							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260 1. Diabetes mellitus 2 Coronary heart disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/30 , 19 57 , to 1/3 , 19 58 , that I last saw the deceased alive on 1/3 , 19 58 , and that death occurred at 9:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4 E. Church St. DATE SIGNED 1/3/1958							
ACTUAL SIGNATURE H. V. Chase		M.D.					
PHYSICIAN'S NAME (Type) Dr. H. V. Chase		Frederick-Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-6-1958		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE 1/6/1958		24b. REGISTRAR'S SIGNATURE He. Deace	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Put and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00635

638

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 25 DeGrange St.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 DeGrange St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) George		First William	Middle Bentz	Last Kathy	4. DATE OF DEATH Jan. 14-1910	Month 1	Day 13	Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14-1910		9. AGE (In years lost birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		10b. KIND OF BUSINESS OR INDUSTRY Brush Mfg. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Arthur Bentz				14. MOTHER'S MAIDEN NAME Florence Wiles							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-5940		17. INFORMANT Mrs. Geo. W. Bentz-25 DeGrange St.-Frederick-		Address Md. 25 DeGrange St.-Frederick-					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)				<i>Coronary thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH 4 days			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Jan. 9, 1958 , to Jan. 13, 1958 , that I last saw the deceased alive on Jan. 12, 1958 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE B.O.Thomas PHYSICIAN'S NAME (Type) Dr. B.O.Thomas								ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED 1-13-1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 16-1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son		W. ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE JAN 15 '58		24b. REGISTRAR'S SIGNATURE Al. Eschuk					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G225 2-3-58 et

00636

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 20 Hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindobona Convalescent & Rest Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) First ELEANOR Middle HARRY Last BEST		d. STREET ADDRESS 29 West Patrick Street	
4. DATE OF DEATH January 26, 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 25 Nov 1870 1869
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years from birthday) yrs. 88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Harry		14. MOTHER'S MAIDEN NAME Mary Hargett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None 17. INFORMANT George Z. Best (Same as item #2)	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Anteriosclerotic Heart Disease year (c) Generalized Anteriosclerosis year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 14, 1957 to 1-26, 1958, that I last saw the deceased alive on 1-24, 1958, and that death occurred at 8:40A M, from the causes and on the date stated above. ACTUAL SIGNATURE Robert S. Turner, Jr. M.D.		ADDRESS (Street, city or town, state) 7 E. Church St., Frederick, Md. DATE SIGNED 1-27-58	
PHYSICIAN'S NAME (Type) Robert S. Turner, Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-29-58	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 26 1958	24b. REGISTRAR'S SIGNATURE O. B. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE AT DEATH	
MILLER, JOHN		65	
ADDRESS		CITY, STATE, ZIP CODE	
101 W. 1ST ST., MILWAUKEE, WIS.		MILWAUKEE, WIS. 53203	
NAME AND ADDRESS OF DOCTOR		NAME AND ADDRESS OF FUNERAL HOME	
DR. JAMES H. KELLY, 101 W. 1ST ST., MILWAUKEE, WIS.		FREDERICKSON'S FURNACE CO., 101 W. 1ST ST., MILWAUKEE, WIS.	
NAME AND ADDRESS OF POLICE OFFICER		NAME AND ADDRESS OF ATTENDING PHYSICIAN	
DET. R. L. HARRIS, MILWAUKEE POLICE DEPARTMENT, 101 W. 1ST ST., MILWAUKEE, WIS.		DR. JAMES H. KELLY, 101 W. 1ST ST., MILWAUKEE, WIS.	
TIME AND PLACE OF DEATH		TIME AND PLACE OF AUTOPSY	
HOME, 101 W. 1ST ST., MILWAUKEE, WIS.		HOME, 101 W. 1ST ST., MILWAUKEE, WIS.	
CAUSE OF DEATH		DEATH CERTIFIED BY	
HEART DISEASE		DR. JAMES H. KELLY	
DATE OF DEATH		DATE OF CERTIFICATION	
JAN 28, 1953		JAN 28, 1953	
RECEIVED		APPROVED	
BUREAU X E		DR. JAMES H. KELLY	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

639

CERTIFICATE OF DEATH

Reg. Dist. No.

110637
131

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 15 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) First HARRY		d. STREET ADDRESS 920 North Market Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 1, 1885
8. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		9. AGE (in years at birthday) 72 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mailing Dept.		10b. KIND OF BUSINESS OR INDUSTRY News-Post	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Valentine S. Carmack		14. MOTHER'S MAIDEN NAME Mary C. Heffner	
15. SOCIAL SECURITY NO. 220-09-7845		16. INFORMANT Mrs. Dorothy G. Carmack-Same as item #2	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral VASCULAR accident, multiple, generalized unknown		INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Anoxic, septic, generalized unknown (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. , 19 57 , to 1-2- , 19 58 , that I last saw the deceased alive on 1-2- , 19 58 , and that death occurred at 7:50P M, from the causes and on the date stated above. ACTUAL SIGNATURE Rex R. Martin		ADDRESS (Street, city or town, state) East Church Street	
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin		DATE SIGNED 1/3/1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 5, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Glade Cemetery		22d. LOCATION (City, town, or county) Walkersville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland		24a. REC'D. BY REGISTRAR DATE JAN 6 1958	
		24b. REGISTRAR'S SIGNATURE R. J. Etchison	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 6 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

672 CERTIFICATE OF DEATH

Reg. Dist. No.

00638

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		d. STREET ADDRESS /			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Cora		First M.	Middle Cartnail	Last Cartnail	4. DATE OF DEATH 1 9 19 58	Month 1	Day 9	Year 58	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/19/1875	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Daniel Dykes		14. MOTHER'S MAIDEN NAME Lydie Walker							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mark A. Cartnail, Middletown, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arterio-sclerosis						INTERVAL BETWEEN ONSET AND DEATH 4 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) 		(County) 	(State)
21. I certify that I attended the deceased from Jan 9 , 19 58 to Jan 9 , 19 58 , that I last saw the deceased alive on Jan 9 , 19 58 , and that death occurred at 4 P.M. from the causes and on the date stated above.						ADDRESS (Street, city, or town, state) Middletown, Md.		DATE SIGNED 1-10-58	
ACTUAL SIGNATURE J. Elmer Harn									
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harn									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/12/1958		22c. NAME OF CEMETERY OR CREMATORIUM A.M.E. Cemetery		22d. LOCATION (City, town, or county) Middletown, Md.		(State) 	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS 		24a. REC'D BY REGISTRAR JAN 14 58		24b. REGISTRAR'S SIGNATURE John Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	
MATERIAL	
DATE OF DEATH	
TIME OF DEATH	
AGE AT DEATH	
SEX	
CAUSE OF DEATH	
DEATH CERTIFIED	
SIGNATURE	
RECEIVED	
BUREAU X.Y.Z.	
JAN 14 1968	
RECEIVED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00639

640

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b About 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 31 South Jefferson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Louise	Last Castle	4. DATE OF DEATH	Month January	Day 21	Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12-17-1886	9. AGE (In years from birth) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trimmer		10b. KIND OF BUSINESS OR INDUSTRY Brush Company		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Abraham Perriman Castle		14. MOTHER'S MAIDEN NAME Jane Rebecca Degrange						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-1840		17. INFORMANT Mr. Douglas Castle-Rt. 4-Frederick-Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X		<i>Pulmonary Embolus</i>				INTERVAL BETWEEN ONSET AND DEATH 1-10-58		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) <i>Carcinoma of Breast</i>				1/2 yrs		
(c) <i>Carcinomatosis</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from _____		to _____		that I last saw the deceased alive on _____		ADDRESS (Street, City or town, state)		
ACTUAL SIGNATURE <i>Frank Damazo M.D.</i>						DATE SIGNED <i>1-23-58</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF Jan. 21-58		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick-Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E.Cline & Son</i>		ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE JAN 24 '58		24b. REGISTRAR'S SIGNATURE <i>W.L. Schuck</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDWARD J. KELLY	40	M	ACUTE COUGH AND SORE THROAT
ADDRESS	STREET	CITY	STATE
101 E. BELMONT ST.	BALTIMORE	MARYLAND	
NAME OF DOCTOR	NAME OF HOSPITAL		
DR. JAMES M. DUNN	HOSPITAL OF THE GOOD SHEPHERD		
TIME OF DEATH	DATE OF DEATH		
10:00 A.M.	JAN 24, 1933		
I declare that the above information is true to the best of my knowledge and belief.			
SIGNED: DR. JAMES M. DUNN			

BUREAU Y. S.

JAN 24 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

641

CERTIFICATE OF DEATH

00640

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X UNION BRIDGE RURAL	
d. STREET ADDRESS JOHNSVILLE		d. STREET ADDRESS JOHNSVILLE	
3. NAME OF DECEASED (Type or print) MARY CATHERINE CHABAUGH		First	Middle
		Last	4. DATE OF DEATH JAN. 5 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/1900
		WIDOWED <input type="checkbox"/>	9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR GARMENT MFG		10b. KIND OF BUSINESS OR INDUSTRY GARMENT MFG	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN H SNYDER		14. MOTHER'S MAIDEN NAME ELFIE WOLFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-10-0520	
		17. INFORMANT V. A. CHABAUGH	
		Address UNION BRIDGE RURAL MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8		INTERVAL BETWEEN ONSET AND DEATH 10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)		DUE TO Recurrent Carcinoma of Colon & Metastases	
		DUE TO (c) Acute angulatory torsion of ileum	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 27, 1957 , to Jan. 5, 1958 , that I last saw the deceased alive on Jan. 4, 1958 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) FREDERICK - Md.	
ACTUAL SIGNATURE Frank Worthington		DATE SIGNED 1958	
PHYSICIAN'S NAME (Type) FRANK WORTHINGTON		FREDERICK MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL JAN 8-58		22b. DATE THEREOF JAN 8-58	
22c. NAME OF CEMETERY OR CREMATORIUM FAIRMOUNT CEM. LIBERTYTOWN MD		22d. LOCATION (City, town, or county) (State) LIBERTYTOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE D.D. Hartly & Sons Union Bridge Md.		24a. REC'D BY REGISTRAR DATE JAN 8 '58	
		24b. REGISTRAR'S SIGNATURE DeLoach	

87 390NTSAB-FI2A9H-90 TRINIDAD AND TOBAGO STATE OF MARCH 1990

BUREAU V.

AN 8 1958

REFEELIVE ED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00641

Reg. Dist. No.

DEPT. OF STATE
HEALTH DEPT.

673

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Henrico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buckeyestown		c. LENGTH OF STAY IN lb Since 9/57	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond ✓ 83X-3	
3. NAME OF DECEASED (Type or print) WARREN HENLEY COFFEY		d. STREET ADDRESS 2207 Fourth Avenue	
4. DATE OF DEATH January 27, 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Nov 1911
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Lumber Company	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Coffey		14. MOTHER'S MAIDEN NAME Ella Clemens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 224-09-3863	
17. INFORMANT Mrs. Orlene Graves Coffey (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO <u>Suffocation</u> Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO <u>Third degree burns</u>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparent Smothering by bed mattress caught face</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. Jan. 27 1957		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. BUCKEYESTOWN (County) <u>Frederick</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>B. O. Thomas</u>		DATE SIGNED 1-27-58	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-28-58	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Richmond, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 29 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Debra</u>	

THE POLICE CHAMBER'S CEREMONY OF DEPUTY
WORCESTER STATE DEPARTMENT OF POLICE-SATURDAYS AT

BUREAU V. S.

JAN 29 1963

REGELIV ED

17

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00642

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Please forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be joined for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

V.S. AT 5ME
SM 2/57

1. PLACE OF DEATH a. COUNTY		674		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick		MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Near Hagerstown		24 yrs		Mt. airy R.F.D. 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	lost	4. DATE OF DEATH
Charlie Everett Condon					January 24 1958
5. SEX		6. COLOR OR RACE	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan 18, 1899	58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Farmer		OWNER		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edward E. Condon		Leontine B. Brown		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		218-32-1070		Hepsey Condon Mt. airy R.D. 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Strangulation by Hanging			
974X		INTERVAL BETWEEN ONSET AND DEATH Minutes			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)			
		DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED			
EXAMINER'S NAME (Type) <i>B.O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1-27-1958</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Prospect</i>	22d. LOCATION (City, town, or county) (State) <i>Frederick Co. md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>S.M. Waltz</i>		ADDRESS <i>Wmfield. Md.</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 27 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Frederick</i>

WISCONSIN STATE DOCUMENTS DEPARTMENT - DIVISION OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE
WISCONSIN

5420

56

A. A.

July 1961

Change

7592054 7-2-61 J.W.H.
Date (initials) (Signature)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

642

CERTIFICATE OF DEATH

00643

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 7/31/43	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Odd Fellows Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4 ✓	
3. NAME OF DECEASED (Type or print)	First BERTHA	Middle A.	Last DICKERSON
4. DATE OF DEATH	Month January	Day 26,	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10 Oct 1871
9. AGE (In years lost/birthday) 66 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Leach		14. MOTHER'S MAIDEN NAME Martha Bailess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Md. Odd Fellows Home (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Hypostatic Pneumonia Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO Bemlity my credits		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1958, to Jan 26, 1958, that I last saw the deceased alive on 19, and that death occurred at 12:55 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE E.P. Thomas		ADDRESS (Street, city or town, state) M.D. 4 E. Church St., Frederick, Md. DATE SIGNED 1-27-58	
PHYSICIAN'S NAME (Type) E. P. Thomas, M. D.		E.P. Thomas	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-58	
22c. NAME OF CEMETERY OR CREMATORIALoudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR ADDRESS DATE JAN 29 '58	
		24b. REGISTRAR'S SIGNATURE DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. A.

JAN 29 1968

REGEIVEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

675

CERTIFICATE OF DEATH

00644

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Frederick								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		c. LENGTH OF STAY IN 1b 7 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown-Rural R.D.#1,										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vindabona Convalescent & Rest Home		d. STREET ADDRESS Near Buckeystown		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print)	First GROVER	Middle CLEVELAND	Last DIXON	4. DATE OF DEATH January 20, 1958	Month Day Year	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 30, 1884	9. AGE (In years lost birthday) 73 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner	11. KIND OF BUSINESS OR INDUSTRY Farming	12. BIRTHPLACE (State or foreign country) Maryland	13. CITIZEN OF WHAT COUNTRY? USA
14. FATHER'S NAME James B. Dixon	15. MOTHER'S MAIDEN NAME Martha Nicholis		16. SOCIAL SECURITY NO. 215-20-9462	17. INFORMANT Mrs. Dallas W. Kehne, Braddock Heights, Maryland	Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Nervous System		DUE TO 442X		INTERVAL BETWEEN ONSET AND DEATH 5 days										
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Hypertension		(c) DUE TO Cardio Vascular Renal Disease		5 years										
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) East Second Street	(County)	(State)									
21. I certify that I attended the deceased from July 5, 1957 , to Jan 20, 1958 , that I last saw the deceased alive on Jan 20, 1958 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE H. L. Fahrney						ADDRESS (Street, city or town, state) Frederick, Maryland	DATE SIGNED 1/21/1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 23, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick	(State) Maryland										
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 23 '58	24b. REGISTRAR'S SIGNATURE W. B. Baugh											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU OF

JAN 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
676 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00645

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
FREDERICK MARYLAND		MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL - KNOXVILLE		RURAL - KNOXVILLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
GEORGE WASHINGTON FLETCHER			
4. DATE OF DEATH		Month	Doy Year
/ / 10 1958			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
MALE NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
LABORER		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
GEORGE WASHINGTON FLETCHER SR.		MARY (UNKNOWN)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT	
NO		FRANKLIN FLETCHER PETERSVILLE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
493X DUE TO			
Conditions, if any, which gave rise to immediate cause (b)			
(a), stating the underlying cause last. DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 1-16-58	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
BURIAL		1-18-58	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
UNION BETHEL		PETERSVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Elva V. Feete Brunswick Md.		24a. REC'D BY REGISTRAR	
		DATE JAN 20 '58	
		24b. REGISTRAR'S SIGNATURE Albert Deuch	

WILLYA AND STATE OF CALIFORNIA - BUREAU OF MEDICAL EXAMINERS CERTIFICATE OF DEATH

STATE OF
CALIFORNIA

BUREAU OF MEDICAL EXAMINERS

AN 20 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00646

CERTIFICATE OF DEATH

Reg. Dist. No. 131

677

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Doubs		c. LENGTH OF STAY IN 1b Since 1893		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Doubs					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOVIE		Middle MAY		Last FRY		4. DATE OF DEATH January 5, 1958	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Dec 1884	9. AGE (In years less birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Silas Umbaugh		14. MOTHER'S MAIDEN NAME Esther Fry							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Elijah D. Fry		Address (Same as item #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO <i>Coronary Occlusion</i>		DUE TO <i>Laminated Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH 3 mo			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Asthma Complete prolapze uterus + Bladder</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>2:20 P.M.</i>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Jefferson, Maryland</i>		20f. (City or town) <i>Jefferson, Maryland</i>		(County) <i>Jefferson, Maryland</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, at _____, from the causes and on the date stated above. A. T. Brice						ADDRESS (Street, city or town, state) <i>Jefferson, Maryland</i>		DATE SIGNED 1-7-58	
ACTUAL SIGNATURE <i>A. T. Brice</i>									
PHYSICIAN'S NAME (Type) A. T. Brice, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS <i>M. R. Etchison & Son, Frederick, Maryland</i>		24a. REC'D BY REGISTRAR <i>Jan 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Debelak</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MURKIN

1938

NAME	AGE	SEX	CAUSE OF DEATH
MURKIN	50	Male	Heart Disease
DECEASED ON JANUARY 9, 1938			
BORN APRIL 1, 1888			
DIED JANUARY 9, 1938			
MAILED TO			
BUREAU OF INVESTIGATION HONOLULU, HAWAII			
JAN 9 1938			

BUREAU OF INVESTIGATION
HONOLULU, HAWAII
RECEIVED JAN 9 1938

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

643

CERTIFICATE OF DEATH

00647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 East Sixth Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Mary		First Elizabeth	Middle Glessner
4. DATE OF DEATH Month January	Day 18	Year 1958	5. SEX Female
6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARATED <input type="checkbox"/>	8. DATE OF BIRTH April 22-1864	9. AGE (In years lost birthday) 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Herman F. Debring		14. MOTHER'S MAIDEN NAME Lucy Grosh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. A. Gregg Glessner-126 E. 3rd St.-Frederick
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Never	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/17 , 19 58 , to 1/17 , 19 58 , that I last saw the deceased alive on 1/17 , 19 58 , and that death occurred at 10:00A.M. from the causes and on the date stated above. ACTUAL SIGNATURE James B. Thomas PHYSICIAN'S NAME (Type) Dr. James B. Thomas			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 21-58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son	ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE C. E. Cline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

CERTIFICATE OF DEATH

SEARCHED

INDEXED

SERIALIZED

FILED

BUREAU V. S.

JAN 22 1968

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

vs AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00648

CERTIFICATE OF DEATH

678

Reg. Dist. No.....

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY	Frederick	MARYLAND	STATE	Maryland	COUNTY
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN	rural-Mt. Airy	60 yrs	TOWN	rural--Mt. Airy	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		(If rural give location)
				nr. Unionville	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
(First) EDNA (Middle) G. (Last) GRIFFITH			JAN. 31, 1958		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR
female	white	widowed	5-16-1870	87 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		
			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME John L. Sundergill			14. MOTHER'S MAIDEN NAME Sarah V. Hartsock		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. none		
17. INFORMANT & ADDRESS John O. Griffith, Same			18. MEDICAL CERTIFICATION <i>Myocardial degeneration Chronic Pneumonia & Bronchitis</i>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
502.1 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> M. <input type="checkbox"/>		
			21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 1-27-1958, to 1-31-, 1958, that I last saw the deceased alive on 1-27-, 1958, and that death occurred at 9 A.M., from the causes and on the date stated above. SIGNATURE <i>J.H. Legg</i> M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			DATE THEREOF 2-3-1958 NAME OF CEMETERY Linganore		
24. REC'D BY REGISTRAR DATE FEB 5 '58			REGISTRAR'S SIGNATURE <i>Al. Leach</i>		
			25. FUNERAL DIRECTOR'S SIGNATURE C.M. Waltz, Winfield, Md.		
			ADDRESS		

RECEIVED IN THE OFFICE OF THE SECRETARY OF STATE

CERTIFICATE OF DEATH

DEATH CERTIFICATE NUMBER

REGISTRATION NUMBER

BUREAU V. S.

FEB 5 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00649

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE AND deceased lived, If institution, Residence before admission a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 West "F" Street				d. STREET ADDRESS 11 West "F" Street		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Lillie	Middle Victoria	Last Halley	4. DATE OF DEATH	Month Jan.	Day 26	Year 1958	
5. SEX W	6. COLOR OR RACE WIDOWED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16 1870	9. AGE (In years at birthday) 87 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Berryville, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William P. Diehl				14. MOTHER'S MAIDEN NAME Mary E. Crider				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Buelah Orndorff Brunswick, Md.		
no		-		-				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1/22 , 19 58 , to 1/26 , 19 58 , that I last saw the deceased alive on 1/25 , 19 58 , and that death occurred at M. , from the causes and on the date stated above. ACTUAL SIGNATURE Brunswick Md 1/27/58		ADDRESS (Street, city or town, state) DATE SIGNED 1/27/58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28 58		22c. NAME OF CEMETERY OR CREMATORIUM Lovettsville Union		22d. LOCATION (City, town, or county) (State) Lovettsville Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Elois J. Seete		ADDRESS Brunswick Md		24a. REC'D BY REGISTRAR JAN 31 '58		24b. REGISTRAR'S SIGNATURE DeLoach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

MAY 20, 1958

DECEASED PERSON'S NAME WILLIAM HENRY COOPER	SEX MALE	AGE AT DEATH 60 years	TIME OF DEATH 10:00 A.M.
ADDRESS 101 E. BELMONT ST. BALTIMORE, MD.	NAME OF DOCTOR DR. JAMES M. COOPER	NAME OF HOSPITAL BELMONT HOSPITAL	NAME OF FUNERAL HOME BELMONT HOSPITAL
CAUSE OF DEATH HEART DISEASE			
DEATH CERTIFIED BY DR. JAMES M. COOPER			
I declare under penalty of perjury that the information contained in this certificate is true and correct.			
SIGNED AND SWORN TO THIS 31st DAY OF MAY, 1958.			
DR. JAMES M. COOPER			

BUREAU OF

May 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

679

CERTIFICATE OF DEATH

Reg. Dist. No.

00650

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont--rural		c. LENGTH OF STAY IN 1b 73 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS X Thurmont -- rural	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle Catherine	Last Hemler
4. DATE OF DEATH	Month January	Day 27	Year 19 58
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1884
9. AGE (in years lost/birthday) 75 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel A. Hemler		14. MOTHER'S MAIDEN NAME Annie Florence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Felix Hemler		Address Thurmont, Md, RD2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH 5 months	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension.			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 10, 1953 , to Jan 29, 1958 , that I last saw the deceased alive on Jan 24, 1958 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles R. Williams M.D.		ADDRESS (Street, city or town, state) Emmettburg Md 128-58	
DATE SIGNED 1-28-58			
PHYSICIAN'S NAME (Type) Dr. Charles R. Williams			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-58	
22c. NAME OF CEMETERY OR CREMATORIUM St. Anthony's Cem.		22d. LOCATION (City, town, or county) Thurmont-- RD2 Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md	
24a. REC'D BY REGISTRAR JAN 30 '58		24b. REGISTRAR'S SIGNATURE Debrauk	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BUREAU V. S.

JAN 30 1968

REGGAE VIBE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00651

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville		c. LENGTH OF STAY IN 1b 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville		d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nettie	Middle E. Hemp	Last	4. DATE OF DEATH	Month 1	Day 24	Year 1958		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME John Flook			14. MOTHER'S MAIDEN NAME Mary McBride			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Mary Clarice Hemp, Burkittsville					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x		<i>Cerebral Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH 3 days					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized arteriosclerosis		<i>Generalized arteriosclerosis</i>		DUE TO 10 yrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Burkittsville		(County) Md.	(State) Md.
21. I certify that I attended the deceased from 1/23, 1958 , to 1/27, 1958 , that I last saw the deceased alive on 1/24, 1958 , and that death occurred at 1:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jefferson Rd DATE SIGNED 1/28/58									
ACTUAL SIGNATURE Miss Mary Clarice AT BRICE		PHYSICIAN'S NAME (Type) AT BRICE							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/28/1958		22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery		22d. LOCATION (City, town, or county) Burkittsville		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR JAN 28 '58		24b. REGISTRAR'S SIGNATURE West Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 23 1953

REGELVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 44652

681

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#3	c. LENGTH OF STAY IN lb 48 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Frederick			d. STREET ADDRESS Near Frederick		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First DAVID	Middle WALTER	Last HOOPER	4. DATE OF DEATH	Month January 13, Day Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 30 April 1894	9. AGE (in years 63 at birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME James Oliver Hooper			14. MOTHER'S MAIDEN NAME Lillie May Stottlemeyer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-7156		17. INFORMANT Mrs. Lucy E. Hooper (Same as item #1) Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO <i>Coronary occlusion</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 1-13-58	
EXAMINER'S NAME (Type) B. O. Thomas, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-17-58	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland			24a. REC'D BY REGISTRAR DATE JAN 14 '58 24b. REGISTRAR'S SIGNATURE <i>W. E. Etchison</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the remains prior to burial, cremation, or removal.

BUREAU V. 8

JAN 14 1969

PERGAMENO

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

644

CERTIFICATE OF DEATH

Reg. Dist. No.

00653

1. PLACE OF DEATH a. COUNTY Hanover Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick 1day		c. LENGTH OF STAY IN 1b Rural --Woodbine 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital		d. STREET ADDRESS Morgan Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First M. Howard	Middle O. Hutchins Jr	Last Jan. 13 1958		
4. DATE OF DEATH	Month Jan.	Day 13	Year 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-1891		
9. AGE (in years lost/birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY owner	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Oliver Hutchins	14. MOTHER'S MAIDEN NAME Mary Ruth Kessler				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-36-3963	17. INFORMANT Mrs. Carrie Lee Hutchins, Same	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 57a.2		INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Hour o. m. — p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Frederick, Md.	(County) Howard Co., Maryland	(State) Maryland
21. I certify that I attended the deceased from Jan 12, 1958 to Jan 13, 1958 that I last saw the deceased alive on Jan 13, 1958 , and that death occurred at 8:50 AM , from the causes and on the date stated above. ACTUAL SIGNATURE A. A. Pearre M.D. ADDRESS (Street, city, town, state) Frederick, Md. DATE SIGNED 1/13/58					
22o. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-16-1958	22c. NAME OF CEMETERY OR CREMATORIAL Harmony	22d. LOCATION (City, town, or county) Howard Co., Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,	ADDRESS Winfield, Md.	24a. REC'D BY REGISTRAR DATE JAN 15 '58			
				24b. REGISTRAR'S SIGNATURE Q. W. Seach	

CERTIFICATE OF DEATH

NAME

AGE

DEATH DATE

BUREAU U.S.

JAN 15 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00654

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural		c. LENGTH OF STAY IN 1b Since 6/30/53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural RD#3	
3. NAME OF DECEASED (Type or print) JAMES CLARENCE JAMES SR. James CLARENCE		4. DATE OF DEATH James, SR. 25, 1958	Month Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 6 Aug 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Milk Inspector	11. BIRTHPLACE (State or foreign country) Alabama
13. FATHER'S NAME William A. James		14. MOTHER'S MAIDEN NAME Mary Pace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT J. Clarence James, Jr. (Same as item #2)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH Acute exacerbation of chronic cystitis + prostatitis App. 3 yrs. 5 - 10 yrs	
DUE TO Prostatic hyper trophy		(b) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio sclerosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) May 24, 1957, to Jan 25, 1958.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 24, 1957, to Jan 25, 1958. that I last saw the deceased alive on Jan. 25, 1958 , and that death occurred at 10¹⁰ P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) New Market, Md. DATE SIGNED Jan. 26, 58			
ACTUAL SIGNATURE Ralph L. Michels M.D.		PHYSICIAN'S NAME (Type) Ralph L. Michels, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-27-58	22c. NAME OF CEMETERY OR CREMATORIAL New Market, Md.
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 28 '58	24b. REGISTRAR'S SIGNATURE DeLoach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

SEARCHED

INDEXED

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BUREAU Y.

JAN 28 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00655

646

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b 2 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK COUNTY HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PERCY	First W.	Middle KELLY	4. DATE OF DEATH Jan 22 1958		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 22-1880		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MERCHANT	10b. KIND OF BUSINESS OR INDUSTRY GROCERY STORE	11. BIRTHPLACE (State or foreign country) MD	12. CITIZEN OF WHAT COUNTRY? WS		
13. FATHER'S NAME JAMES M. KELLY	14. MOTHER'S MAIDEN NAME EMMA SWONLEY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 217-12-3014	17. INFORMANT JOHN D. KELLY	Address NEWMARKET MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arterio sclerosis (c) DUE TO Chronic myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) New Market	(County) Frederick	(State) MD
21. I certify that I attended the deceased from Jan 21 , 1958, to Jan 21 , 1958, that I last saw the deceased alive on Jan 21 , 1958, and that death occurred at New Market , from the causes and on the date stated above.					
ACTUAL SIGNATURE H. Kline	ADDRESS (Street, city or town, state) M.D. 7 Newmarket Frederick MD			DATE SIGNED Jan 21 1958	
PHYSICIAN'S NAME (Type) V.E. Falconer					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-24-1958	22c. NAME OF CEMETERY OR CREMATORIAL NEWMARKET CEM	22d. LOCATION (City, town, or county) (State) NEWMARKET MD		
23. FUNERAL DIRECTOR'S SIGNATURE V.E. Falconer New Market MD	ADDRESS	24a. REC'D BY REGISTRAR JAN 24 1958	24b. REGISTRAR'S SIGNATURE Det. 11		

MEXICAN STATE GOVERNMENT OF MEXICO-CALIFORNIA

CERTIFICATE OF DEATH

BUREAU Y.

JAN 27 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

647

CERTIFICATE OF DEATH

Reg. Dist. No. 00656

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Memorial		c. LENGTH OF STAY IN lb 57 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 639 Park Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sadie Sashi		First Sadie	Middle Lucinda
Last Kesselring		4. DATE OF DEATH January 7 1958	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH March 21-1883		9. AGE (In years lost birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George M. Heim		14. MOTHER'S MAIDEN NAME Ida V. Gunkel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Wm. H. Bierley- Wilson Pl. Frederick-Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Anterior septal Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 4 day	
DUE TO H2O Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			
DUE TO Arteriosclerotic Heart Disease (c)		yes	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1, 1954 , to Jan 7, 1958 , that I last saw the deceased alive on Jan 7, 1958 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4 W 3rd St	
ACTUAL SIGNATURE Thomas E. Stone M.D.		DATE SIGNED 1-7-58	
PHYSICIAN'S NAME (Type) Thomas E. STONE		Frederick Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE John Cline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Forms 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
 ISM 9/55

CERTIFICATE OF DEATH

DECEASED PERSON'S NAME	AGE	SEX	CAUSE OF DEATH
EDWARD J. KELLY	55	Male	Cardiac Arrest
ADDRESS	DATE OF DEATH	TIME OF DEATH	PLACE OF DEATH
100 E. 12th Street	1965-01-01	10:00 AM	Hospital
NAME AND ADDRESS OF PHYSICIAN	NAME AND ADDRESS OF HOSPITAL	NAME AND ADDRESS OF FUNERAL DIRECTOR	
Dr. John C. Smith 100 E. 12th Street	Hospital of the Good Shepherd 100 E. 12th Street	John C. Smith 100 E. 12th Street	
I declare under penalty of perjury that the information contained in this certificate is true and correct.			
Signed: Dr. John C. Smith			

BUREAU U. S.

JAN 10 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00657

682

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederikkk MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural New Market	c. LENGTH OF STAY IN 1b 13 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyd's, Rural. (Dawsonsville)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital		d. STREET ADDRESS Rural	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
15X-2	15X-2	15X-2	15X-2
3. NAME OF DECEASED (Type or print) James Deets King	First Middle Last	4. DATE OF DEATH Jan 10	Day Year 1958 19
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb 4 1889
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months 11 Days 6	11. IF UNDER 24 HRS. Hours 6 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Montg., Co., Maryland U.S.A.
13. FATHER'S NAME Elias Dorsey King		14. MOTHER'S MAIDEN NAME Gertrude Lawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Macie Schaeffer King, Boyd's, Md.
			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 331X Cerebral Hemorrhage 3 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		cerebral arteriosclerosis 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cardiac thrombosis auricular fibrillation		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased fram. Dec 20, 1957, Jan 10, 1958, that I last saw the deceased alive on Jan 10, 1958, and that death occurred at a. M., fram the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Ijamsville, Md. Feb 10, 1958	
ACTUAL SIGNATURE Joseph Lerner M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-13-58	22c. NAME OF CEMETERY OR CREMATOR Y Mt Olivet
22d. LOCATION (City, town, or county) Frederick, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Al. Keenick
VS A15 (4) 15M 9/55		DATE JAN 14 '58	

BUREAU Y.

JAN 14 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00658

648

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 8 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 229 Phebus Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Zachary	First Zachary	Middle Lynn	Last King	4. DATE OF DEATH Jan. 24	Month Jan.	Day 24	Year 1958		
S. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14-57	9. AGE (In years last birthday) 6	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) Frederick, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Carroll L. King		14. MOTHER'S MAIDEN NAME Beatrice Bowie							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) *****		16. SOCIAL SECURITY NO. *****		17. INFORMANT Beatrice Bowie King - 229 Phebus Ave. Fred. Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Bronchial pneumonia				INTERVAL BETWEEN ONSET AND DEATH 3-4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month Jan.	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 35 East Church St. Frederick, Md.	(County) 35 East Church St. Frederick, Md.	(State) 35 East Church St. Frederick, Md.		
21. I certify that I attended the deceased from 1-24 , 19 58 , to 1-24 , 19 58 , that I last saw the deceased alive on 1-24 , 19 58 , and that death occurred at 11 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Rex R. Martin	ADDRESS (Street, city or town, state) 35 East Church St. Frederick, Md.		DATE SIGNED 35 East Church St. Frederick, Md.						
PHYSICIAN'S NAME (Type) Rex R. Martin	22d. LOCATION (City, town, or county) Della-Fred. Co. Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-28-58	22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls							
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III Frederick, Md.			ADDRESS Charles E. Hicks III Frederick, Md.	24a. REC'D BY REGISTRAR FEB 3 '58	24b. REGISTRAR'S SIGNATURE Charles E. Hicks III Frederick, Md.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	PLACE OF DEATH
WILLIAM H. COOPER	50	Male	Hospital
ADDRESS	STATE	CITY	ZIP
100 E. 36th Street	Maryland	Baltimore	21205
RELATIONSHIP TO DECEASED	DEATH CERTIFICATE NUMBER	DATE ISSUED	ISSUED BY
Son	99-12345678	1958	CLERK
INSTRUCTIONS: Fill in all applicable spaces. If any space is not applicable, leave blank.			
1. Name of deceased:			
2. Age at time of death:			
3. Sex:			
4. Place where deceased died:			
5. Address of deceased:			
6. State, city, and zip code:			
7. Relationship to deceased:			
8. Death certificate number:			
9. Date issued:			
10. Issued by:			

BUREAU V. S.

EB 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00659

Item 12, Film G224, 1/22/58

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick MARYLAND		d. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b 51	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 6 West Third Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Johanna	Middle Christiana	Last Kintz
4. DATE OF DEATH January 15 1958	Month Day Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> SEPARETED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-1877
9. AGE (In years lost birthday) 80 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Frankfort Germany
13. FATHER'S NAME Carl Heinrich	14. MOTHER'S MAIDEN NAME Dorothea Gerbig		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 212-24-5436	17. INFORMANT Carl H. Kintz-6 W. 3rd. St.-Frederick-Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Colloid Goiter			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1955 to Jan 15, 1958, that I last saw the deceased alive on Jan 14, 1958, and that death occurred at 5:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Physician's Name (Type) Dr. Robert S. Turner	ADDRESS (Street, city or town, state) M.D. 78 Church St. Fred, Md. 1-1758 DATE SIGNED 1-17-58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-18-1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Cline & Son	W.	ADDRESS Frederick Maryland	24a. REC'D BY REGISTRAR DATE JAN 20 '58
		24b. REGISTRAR'S SIGNATURE Rehseich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4
 and 2 should be held with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	50	Male	Cardiac Arrest
ADDRESS	STREET	CITY	STATE
100 W. ST. GEORGE	ST. GEORGE	MARYLAND	
NAME AND ADDRESS OF DOCTOR	STREET	CITY	STATE
DR. JAMES M. COOPER	100 W. ST. GEORGE	ST. GEORGE	MARYLAND
TIME OF DEATH	DATE	TIME	
10:00 A.M.	JAN 20	1959	
BUREAU OF ST. GEORGE			

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00660

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be joined for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Frederick MARYLAND		a. STATE Maryland	b. COUNTY Frederick
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near New Market		c. LENGTH OF STAY IN lb X New Market	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Edward	Middle Samuel
4. DATE OF DEATH		Last Lease	Month Janurary Day 8 Year 19 58
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Male White WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) December 4, 1876 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		11. BIRTHPLACE (State or foreign country) Frederick Co.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Lucinda Poole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-14-6003	
17. INFORMANT		Address Norman S. Lease New Market, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERNAL BETWEEN ONSET AND DEATH 10 Minutes	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B.O. Thomas</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. Thomas		January 8, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Jan. 11, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEM.		22d. LOCATION (City, town, or county) FREDERICK, MARYLAND. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dalley Jr.</i> DAILEY'S FUNERAL HOME		ADDRESS FREDERICK, MD.	
24a. REC'D BY REGISTRAR DATE JAN 13 '58		24b. REGISTRAR'S SIGNATURE <i>Asst. Secy.</i>	

MAURITANIA STATE GOVERNMENT OF LIBERTY - GRANDMOEIS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S

JAN 13 1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00661
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown-Rural RD#1		c. LENGTH OF STAY IN 1b 50 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown-Rural RD#1		d. STREET ADDRESS Near Flint Hill		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Near Flint Hill				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle THOMAS	Last LEE	4. DATE OF DEATH Month January Day 14, Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 79 ? yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frank Lee				14. MOTHER'S MAIDEN NAME Martha Whims				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-5436		17. INFORMANT Mrs. Flora N. Lee (Same as item #1)		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Uremia</u> INTERVAL BETWEEN ONSET AND DEATH 5 Days 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Possible Carcinoma of Prostate</u> ? (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>B. O. Thomas</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-17-58</u>		
EXAMINER'S NAME (Type) B. O. Thomas, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-58		22c. NAME OF CEMETERY OR CREMATORIUM Hope Hill Cemetery		22d. LOCATION (City, town, or county) (State) Frederick County Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. R. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <u>W. E. Etchison</u>		

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by our files.

CORONER DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEVADA - LAS VEGAS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FBI
BUREAU OF INVESTIGATION

AN 20 1958

LEADERSHIP

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

650

CERTIFICATE OF DEATH

00662

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 36 years						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 West Fifth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Martha Jane Smith Sprinkle Little		First Martha	Middle Jane					
4. DATE OF DEATH January 4	Month January	Day 4	Year 19 58					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> UNMARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> WIDOWER <input type="checkbox"/>	8. DATE OF BIRTH May 15-1874					
9. AGE (In years last birthday) 83	10. IF UNDER 1 YEAR yrs. 83	11. IF UNDER 24 HRS. Months 83	12. IF UNDER 24 HRS. Dys 83					
13. FATHER'S NAME George B. Smith	14. MOTHER'S MAIDEN NAME Mary Susan Eyler	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-10-3247D	17. INFORMANT Albert C. Sprinkle- 633 Grant Place-Frederick-	Address Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Coronary			<i>Acute myocardial infarction</i>			INTERVAL BETWEEN ONSET AND DEATH 12 hours		
(b) DUE TO Diabetes mellitus			<i>Severe</i>			1/7/58		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1) diabetes mellitus						
20c. TIME OF INJURY Hour o. m. p. m.	Month Jan	Day 4	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Professional Bldg.	20f. (City or town) Frederick	(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from January , 19 50 , to Jan 4 , 19 58 , that I last saw the deceased alive on Jan 3 , 19 58 , and that death occurred at 3:30A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Professional Bldg. DATE SIGNED S. Schoolman								
ACTUAL SIGNATURE		M.D. Dr. L.R. Schoolman						
PHYSICIAN'S NAME (Type)		Frederick-Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-7-1958		22c. NAME OF CEMETERY OR CREMATORIY St. Johns Cemetery		22d. LOCATION (City, town, or county) Frederick (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Cline & Son		ADDRESS Frederick-Maryland		24a. REC'D BY REGISTRAR DATE JAN 7 '58		24b. REGISTRAR'S SIGNATURE DeLoach		

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BUREAU V.

JAN 7 1953

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film C224 1-20-58 et
651 CERTIFICATE OF DEATH

Reg. Dist. No.

00663

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be retained with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK		c. LENGTH OF STAY IN 1b YEARS 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marker	First ELSWORTH	Middle Lovell	Last / 13 1958
4. DATE OF DEATH / / /	Month 1	Day 13	Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2/12/1887
		WIDOWED <input type="checkbox"/>	C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL NEW WINDSOR 068-2
8. MARRIED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 70	10. IF UNDER 1 YEAR Months 0
		Yrs. 0	Days 0
11. BIRTHPLACE (State or foreign country) MARYLAND	12. IF UNDER 24 HRS. Hours 0	13. CITIZEN OF WHAT COUNTRY? USA	Min. 0
14. FATHER'S NAME ELSWORTH LOVELL	15. MOTHER'S MAIDEN NAME MARTHA E HAINES	Address RURAL NEW WINDSOR MD	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? NO (Yes, no, or unknown) (If yes, give war or dates of service)	17. SOCIAL SECURITY NO. 214-34-4084	18. INFORMANT GRACE C LOVELL	INTERVAL BETWEEN ONSET AND DEATH 8 hours.
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Cardiovascular Disease 3 yrs +			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/12 , 19 58 , to 1/13 , 19 58 , that I last saw the deceased alive on 1/12 , 19 58 , and that death occurred at 2:30 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4 E. Church St	
ACTUAL SIGNATURE Henry V Chase		DATE SIGNED 1/13/58	
PHYSICIAN'S NAME (Type) Henry V. Chase		22d. LOCATION (City, town, or county) (State) CARROLL CO MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/15/58	22c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE D. Hartzer & Son New Windsor Md		24a. REC'D BY REGISTRAR JAN 15 58	
		24b. REGISTRAR'S SIGNATURE John L. French	

21. Задачи-рассказы по тематике 3 класс нач. школы

S'ANNUARIO

AN 15 1953

REGELY ED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
652 CERTIFICATE OF DEATH

00664

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mrs Lucy Eisenhauer</i>	First <i>McCurdy</i>	Middle <i>Lucy</i>	Last <i>Eisenhauer</i>		
4. DATE OF DEATH <i>Jan 7 1958</i>	Month <i>Jan</i>	Day <i>7</i>	Year <i>1958</i>		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/>	8. DATE OF BIRTH <i>7-29-1877</i>		
9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months No	11. IF UNDER 24 HRS. Days No	12. IF UNDER 24 HRS. Hours No		
13. FATHER'S NAME John Eisenhauer	14. MOTHER'S MAIDEN NAME Margaret Whenner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Charles Byerly-Jr.— N. Markt. St.—Frederick-Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Arteriosclerotic Heart Disease (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 6 mo. 2 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Advanced Rheumatoid Arthritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —				
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) Frederick	(County) Maryland	(State)
21. I certify that I attended the deceased from Jan 1, 1957 , to Jan 7, 1958 , that I last saw the deceased alive on Jan 7, 1958 , and that death occurred on Jan 7, 1958 , P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frederick, Md.					
ACTUAL SIGNATURE <i>A.A. Pearce</i>	M.D.		DATE SIGNED 1/8/58		
PHYSICIAN'S NAME (Type) Dr. A.A. Pearce					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 10-1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick	(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E. Cline & Son</i>	ADDRESS Frederick-Maryland	24a. REC'D BY REGISTRAR JAN 10 1958	24b. REGISTRAR'S SIGNATURE <i>John Pearce</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

WISCONSIN STATE DOCUMENTS LIBRARY - SALINOBIE, JR

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDWARD J. KELLY	50	Male	Heart Disease
ADDRESS	STREET	CITY	STATE
100 W. 10th Street	10th Street	Milwaukee	Wisconsin
NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL HOME	NAME OF CEMETERY
Dr. John J. Kelly	Methodist Hospital	John J. Kelly	Woodlawn Cemetery
TIME OF DEATH	DATE OF DEATH	TIME OF FUNERAL	DATE OF BURIAL
10:00 A.M.	January 10, 1935	10:00 A.M.	January 10, 1935
I declare under penalty of perjury that the information contained in this certificate is true and correct.			
Milwaukee, January 10, 1935			
Edward J. Kelly			
Witnessed by:			
John J. Kelly			

BUREAU V. S.

JAN 10 1935

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00665

685 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN lb 21 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Thurmont		d. STREET ADDRESS /			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Perry	Middle Osgood	Lost McKinney	4. DATE OF DEATH	Month Jan.	Day 17	Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Apr. 24, 1890	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Boston, Mass.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John McKinney		14. MOTHER'S MAIDEN NAME Elisa Dennison							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I 271-03-3686		17. INFORMANT Army record		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart disease Chr. Valvular type						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
421.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO									
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. No		Month 19	Day 19	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Ft. Meyer, Va.	(County) Ft. Meyer, Va.	(State) Va.
21. I certify that I attended the deceased from Jan. 15, 1958 , to Jan. 16, 1958 , that I last saw the deceased alive on Jan. 16, 1958 , and that death occurred at 702 M. from the causes and on the date stated above. ACTUAL SIGNATURE James T. Gray		ADDRESS (Street, city or town, state) Thurmont Md. DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-21-58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington Nat. Cem.		22d. LOCATION (City, town, or county) Ft. Meyer, Va.			(State) Va.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR JAN 22 '58		24b. REGISTRAR'S SIGNATURE Asst. coach			

CERTIFICATE OF DEATH

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BUREAU V.

JAN 22 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

668

CERTIFICATE OF DEATH

00666

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick Md.		b. COUNTY Loudoun	
c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lovettsville, Virginia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 West 1 St.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Catherine Morgan		First	Middle
		Last	
4. DATE OF DEATH January 23 1958		Month	Day
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 1, 1877
8. AGE (In years lost birthday) 80 yrs.		9. IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Louise Stream	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia Monroe		Address 1029 4th St. N.E. Washington D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Cerebral Hemorrhage 12 hrs Arterosclerosis to b	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/20/58 to 1/23/58 , that I last saw the deceased alive on 1/20/58 , and that death occurred on 1/23/58 at Brunswick, Md. , from the causes and on the date stated above. ACTUAL SIGNATURE Dr. J. G. F. Smith PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) Brunswick, Md. DATE SIGNED 1/26/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 26, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Colored Cemetery		22d. LOCATION (City, town, or county) Lovettsville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 27 '58	24b. REGISTRAR'S SIGNATURE D. W. Etchison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST-3901788-12-38-10-19211800-042-0001788

SUREAU Y. S.

JAN 27 1963

RECEIVE ELL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 F11mG22L 1-20-58 et. 00667

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>FREDERICK</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>M.D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>1 lb</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Fredrick Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs Blanche</i>		First <i>M</i>	Middle <i>ella</i>
4. DATE OF DEATH <i>Jan 11 1958</i>		Last <i>J</i>	Month <i>Jan</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May 28 1878</i>		9. AGE (In years from birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>
			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. E. Cecilia James</i>
			Address <i>Fredrick MD</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Heterostatic Carcinoma (Bone - Pelvis) from Uterus.</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 1 1958</i> to <i>Jan 11 1958</i> that I last saw the deceased alive on <i>Jan 11 1958</i> and that death occurred at <i>12:00 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Frederick, Md.</i> DATE SIGNED <i>1/13/58</i>	
ACTUAL SIGNATURE <i>A. J. Pearce</i>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/14/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clarence County Fredrick Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 15 '58
			24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>

CERTIFICATE OF DEATH

REGISTRATION
NUMBER

NAME

NAME

STREET OR ROAD

BUREAU V. A.

JAN 15 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

669

CERTIFICATE OF DEATH

00668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural and nearest town Brunswick		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 East "B" Street				d. STREET ADDRESS 8 East "B" Street		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Louise			Virginia	Painter	Jan.	22	1958	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 8 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug 31, 1876	Months Days Hours Min.	Months	Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cabletown, West Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles William Clipp				14. MOTHER'S MAIDEN NAME Sarah Clipp				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Luther Deener Brunswick, md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Cervix, thrombosis Generalized arteriosclerosis Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH Mr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, AM, from the causes and on the date stated above. ACTUAL SIGNATURE _____ M.D.						ADDRESS (Street, city or town, state) Brunswick, Md.		DATE SIGNED 1-24-58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25		22c. NAME OF CEMETERY OR CREMATORIUM Edge-Hill Charlestown		22d. LOCATION (City, town, or county) Charlestown		(State) W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Elva U. Fueter		ADDRESS Brunswick, Md.		24a. REC'D BY REGISTRAR DATE JAN 27 '58		24b. REGISTRAR'S SIGNATURE DeLoach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEXICAN STATE GOVERNMENT OF HESSEN-AUSTRALIA

CERTIFICATE OF DEATH

NAME	AGE	SEX	DEATH DATE	DEATH PLACE
JOSEPHINE	40	F	1938-01-07	MOSCOW
ADDRESS	STREET	CITY	STATE	POSTAL CODE
12345	MAIN ST	MOSCOW	RUSSIA	12345
RELATIONSHIP	NAME	AGE	SEX	DEATH DATE
WIFE	JANE	35	F	1938-01-07
CHILDREN	JOHN	10	M	1938-01-07
CHILDREN	MARY	8	F	1938-01-07
CHILDREN	CHARLES	5	M	1938-01-07
CHILDREN	ELIZABETH	3	F	1938-01-07
CHILDREN	ROBERT	1	M	1938-01-07
WITNESSES	JOHN	30	M	1938-01-07
WITNESSES	MARY	28	F	1938-01-07
RECEIVED	JAN 07 1938			
BUREAU V.				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

686

CERTIFICATE OF DEATH

00669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md		b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountaintdale		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountaintdale (Thurmont R.D.I.)		d. STREET ADDRESS /				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Charles	Middle H.	Lost	4. DATE OF DEATH Jan. 21, 1958	Month Jan.	Day 21	Year 1958		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1958 1873	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter & Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Frederick Co., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Thomas F. Palmer				14. MOTHER'S MAIDEN NAME Susan Wachter						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Estella E. Palmer Thurmont R.D.I. MD		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebral hemorrhage Hypertensive arteriosclerotic cardiovascular disease. (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hours				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aortic aneurism, descending arch										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Walkersville	(County) MD	(State) MD
21. I certify that I attended the deceased from Augt , 19 58 , to 21 Jan , 19 58 , that I last saw the deceased alive on 21 Jun , 19 58 , and that death occurred at 7 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE James E. Stoner Jr.						ADDRESS (Street, city or town, state) Walkersville MD				DATE SIGNED 1/22/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 24, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cem.		22d. LOCATION (City, town, or county) Lewistown Fredk Co. MD		(State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Greager		ADDRESS Thurmont MD.		24a. REC'D BY REGISTRAR JAN 27 '58		24b. REGISTRAR'S SIGNATURE W. E. Greager				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81.3W071A8-872A8H TO TWA1118A83G 07A72 QW1178A

BUREAU V.

JAN 27 1968

REGELV ELL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

687

CERTIFICATE OF DEATH

Reg. Dist. No.

00670

1. PLACE OF DEATH a. COUNTY Fredrick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. LENGTH OF STAY IN lb 65 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Earle	Middle James	Last Peddicord	4. DATE OF DEATH	Month January	Day 12	Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-1890	9. AGE (In years last birthday) 67	10. IF UNDER 1 YEAR yrs. Months	11. IF UNDER 24 HRS. Days Hours	12. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat cutter		10b. KIND OF BUSINESS OR INDUSTRY Slaughter house		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Peddicord				14. MOTHER'S MAIDEN NAME Laura Weller				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 2200-5-6039		17. INFORMANT Mrs. Ruth Peddicord		Address Thurmont, Md.,		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) birrhosis of the liver DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 3 mos.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct. 1 - 1957 to Jan. 12, 1958 , that I last saw the deceased alive on Oct. 1 - 1957 , and that death occurred at Thurmont, Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Thurmont - Md. DATE SIGNED 1958								
ACTUAL SIGNATURE James K. Gray M.D.								
PHYSICIAN'S NAME (Type) Dr. James K. Gray								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-58		22c. NAME OF CEMETERY OR CREMATORIUM United Brethren Cem		22d. LOCATION (City, town, or county) (State) Thurmont, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR DATE JAN 15 '58		
						24b. REGISTRAR'S SIGNATURE Allesquech		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME

DEATH DATE

AGE

SEX

CAUSE

TIME

PLACE

BUREAU V. S.

JAN 15 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00671

654

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Laura	Middle Elizabeth	Last Pendleton
4. DATE OF DEATH	Month January	Day 25	Year 19 58
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18 1908
9. AGE (In years last birthday) 49	10. IF UNDER 1 YEAR Months 49	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Frederick, Co. Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Albert Brown	14. MOTHER'S MAIDEN NAME Mamie Edwards		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT John H. Pendleton-Monrovia Rt. 1 Fred. Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Insulin shock			
260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes, Melitus			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrene of foot, left			
INTERVAL BETWEEN ONSET AND DEATH Hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) ADDRESS (Street, city or town, state) 228 N Market St., Frederick, Md.		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/24 , 19 58 , to 1/25 , 19 58 , that I last saw the deceased alive on 1/24 , 19 58 , and that death occurred at 7:10P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James B. Thomas,	ADDRESS (Street, city or town, state) 228 N Market St., Frederick, Md.		
PHYSICIAN'S NAME (Type) J.B. Thomas	DATE SIGNED 1/28/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-29-58	22c. NAME OF CEMETERY OR CREMATORIUM Fairview	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III	ADDRESS Frederick, Md.	24a. REC'D BY REGISTRAR DATE FEB 2 '58	24b. REGISTRAR'S SIGNATURE DeLoach

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00672

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		655 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		Maryland b. COUNTY		
Frederick				Frederick		Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b over 60 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 115 North Bentz Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle Warner	Last Pickett	4. DATE OF DEATH	Month January	Day 11	Year 1958
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.	
Male	White		July 1-1874	83 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Salesman		Wholesale Grocery		Maryland		U.S.A.		
13. FATHER'S NAME Peter Pickett				14. MOTHER'S MAIDEN NAME Susan Condon				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Frederick-Md. Charles S. Pickett, Jr.-115 N. Bentz St.		
No		214-10-3546						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Myocardial Infarct & artery stenosis (c)						INTERVAL BETWEEN ONSET AND DEATH 10 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 10, 1958, to Jan. 11, 1958, that I last saw the deceased alive on Jan. 10, 1958, and that death occurred at 8:30 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>B.O.Thomas</i> M.D. Professional Bldg.						ADDRESS (Street, city or town, state) DATE SIGNED		
PHYSICIAN'S NAME (Type)		Dr. B.O.Thomas-Sr. Frederick-Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-1958		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.E.Cline & Son</i>		ADDRESS Frederick-Maryland 24a. REC'D BY REGISTRAR DAN 15 '58 24b. REGISTRAR'S SIGNATURE <i>D. L. Smith</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

CERTIFICATE OF DEATH

Form No. 3

MD 1950

DECEASED PERSON'S NAME

DATE OF DEATH

EXAMINER

SEX

AGE

RACE

HEIGHT

WEIGHT

HAIR COLOR

EYES

SKIN COLOR

RELIGION

EDUCATION

OCCUPATION

EMPLOYER

MATERIAL TESTED

TESTS

TEST

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-tomb permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00673

656 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Enroute to hospital		c. LENGTH OF STAY IN 1b 1b				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JANET	Middle IRENE	Last Powell			
4. DATE OF DEATH	Month January	Day 27	Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1957			
9. AGE (In years last birthday) yrs. 50	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas N. Powell		14. MOTHER'S MAIDEN NAME Constance Mae Grim				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Thomas N. Powell Woodsboro, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 525X				
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO Interstitial pneumonitis, viral etiology		(c) DUE TO 12 hrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) WALKERSVILLE, Md.	20f. (City or town) WALKERSVILLE	(County) Frederick	(State) Maryland
21. I certify that I attended the deceased from 27 Jan , 1958, to 27 Jan , 1958, that I last saw the deceased alive on 27 January, 1958 , and that death occurred at 10 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) WALKERSVILLE, Md.		
ACTUAL SIGNATURE James E. Stoner, Jr.		M.D.		DATE SIGNED 28 Jan 58		
PHYSICIAN'S NAME (Type) James E. Stoner, Jr.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-58		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope Cemetery	22d. LOCATION (City, town, or county) Woodsboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Maryland		24a. REC'D BY REGISTRAR JAN 30 '58	24b. REGISTRAR'S SIGNATURE Outpatient	

MICHIGAN STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	52	M	HEART DISEASE
ADDRESS	STREET	CITY	STATE
1111 WOODSTOCK	DETROIT	DETROIT	MI
NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL HOME	NAME OF CEMETERY
DR. JAMES M. COOPER	HOSPITAL	DETROIT	DETROIT
RELATIONSHIP TO DECEASED	NAME OF SPOUSE	NAME OF CHILDREN	NAME OF PARENTS
WIFE	MARY E. COOPER	JOHN COOPER	WILLIAM COOPER
DEATH DATE	TIME OF DEATH	DEATH CERTIFICATE NUMBER	DEATH CERTIFICATE DATE
JAN 30 1958	10:00 AM	123456789	JAN 30 1958
APPROVAL			
FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE			

JAN 30 1958

FEDERAL BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

657

CERTIFICATE OF DEATH

110674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 7 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital		d. STREET ADDRESS 246 East Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle WALLACE	Last PYLES	4. DATE OF DEATH	Month January	Day 25,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 Sept 1869	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William W. Pyles		14. MOTHER'S MAIDEN NAME Emmaline Price					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Nettie Barthlow (Same as item #2)	Address				
18. CAUSE OF DEATH [Enter only one cause per line] for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 27 yrs.					
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Cirrhosis (c) DUE TO Arteriosclerosis		27 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 7 N. Market St., Frederick, Md.	(County)	(State)
21. I certify that I attended the deceased from Aug 24, 1957 , to Aug 25, 1957 , that I last saw the deceased alive on Aug 24, 1957 , and that death occurred at 5:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7 N. Market St., Frederick, Md. DATE SIGNED 1-27-58							
ACTUAL SIGNATURE <i>H. F. Kline</i>	PHYSICIAN'S NAME (Type) H. F. Kline, M. D.						
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 1-28-58	22c. NAME OF CEMETERY OR CREMATORIUM Epsicopal Cemetery	22d. LOCATION (City, town, or county) Urbana, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 28 1958	24b. REGISTRAR'S SIGNATURE <i>Asst. Registrar</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

688

CERTIFICATE OF DEATH

00675

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Middletown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Estie	Middle M.	Last Routzahn	4. DATE OF DEATH	Month 1	Day 5	Year 1958	
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Carlton Younkins				14. MOTHER'S MAIDEN NAME Sarah Sigler					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Theodore Routzahn, Middletown, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. Month Day Year p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Middleton		20f. (City or town) Middleton		(County) Middleton	(State) Md.
21. I certify that I attended the deceased from Jan 3 , 1958, to Jan 5 , 1958, that I last saw the deceased alive on Jan 5 , 1958, and that death occurred at Middleton , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE Elmer Harp						DATE SIGNED 1-5-58			
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp				Middletown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/8/1958		22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery		22d. LOCATION (City, town, or county) Middletown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 9 '58		24b. REGISTRAR'S SIGNATURE DeLoach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. E.

JAN 9 1958

REGELVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00676

658

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1. PLACE OF DEATH o. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN lb Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 College Avenue	d. STREET ADDRESS 20 College Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LEWIS	Middle WILLIAM	Last AUGUSTUS	4. DATE OF DEATH Month January Day 9, Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Sept 1899	9. AGE (in years ^{last birthday}) 58 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed—Plumbing & Heating Contractor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harry Rowe		14. MOTHER'S MAIDEN NAME Bertha Moberly				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2595		17. INFORMANT Mrs. Maude E. Rowe (Same as item #1)		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) DUE TO (c) primary site unknown, but probably gastro-intestinal						INTERVAL BETWEEN ONSET AND DEATH onset Sept. 1957
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3 Sept 1957 to 9 Jan 1958, that I last saw the deceased alive on 6 January 1958, and that death occurred at 10:35 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Charles H. Conley, Jr.				ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md.		DATE SIGNED 1-10-58
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 3 '58		24b. REGISTRAR'S SIGNATURE Alt. Etchison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED	DEPT. OF JUSTICE FBI - BALTIMORE
JAN 12 1968	
BUREAU V. S.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00677

659

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK, MD.		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME FOR THE AGED		e. STREET ADDRESS 111 E. PATRICK ST	
3. NAME OF DECEASED (Type or print) ANN MIRIA		First ELIZABETH	Middle SCHROEDER
4. DATE OF DEATH JANUARY 27 1958		Lost	Month Day Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Nov. 19, 1868
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	9. AGE (In years lost at death) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Frederick, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME FREDERICK SCHROEDER	
14. MOTHER'S MAIDEN NAME SOPHIA W. HORNING		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOME FOR THE AGED	Address 115 Record St. Frederick, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			
433.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)	<i>Armed</i> <i>Congestive heart failure</i> 1 month
		DUE TO (c)	<i>Atrial Fibrillation</i> 4 mos
INTERVAL BETWEEN ONSET AND DEATH 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 8, 1957 to 27 Jan, 1958 , that I last saw the deceased alive on 1/27, 1958 , and that death occurred at 111 E. Patrick St. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles H. Conley Jr.</i>		ADDRESS (Street, city or town, state) FREDERICK, FREDERICK CO., MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 30	22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEMETERY
22d. LOCATION (City, town, or county) FREDERICK		(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Hailey Jr.</i>		ADDRESS Frederick, Md.	24a. REC'D BY REGISTRAR JAN 31 '58
		24b. REGISTRAR'S SIGNATURE <i>Deborah</i>	

WYOMING STATE GOVERNMENT OF NEVADA - CALIFORNIA

CERTIFICATE OF DEATH

DEATH CERTIFICATE

BURLAU X
REGELIV E
JAN 31 1958

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be submitted within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**689 CERTIFICATE OF DEATH**

00678

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY **Frederick**
 CITY (If outside corporate limits, write RURAL
OR and give nearest town)
 TOWN **Rural Myersville**

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

MARYLANDLENGTH OF STAY
(in this place)**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE **Md.** COUNTY **Frederick**
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN **Rural Myersville**
 STREET ADDRESS

**3. NAME OF
DECEASED
(Type or Print)**(First) **Minnie** (Middle) **V.** (Last) **Shank**

5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 6/20/1876	9. AGE last birthday 81 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. (Year)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife**10b. KIND OF BUSINESS OR INDUSTRY **own home**11. BIRTHPLACE (State or foreign country) **Md.**12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME

James Firestone

14. MOTHER'S MAIDEN NAME

Emma Whipp15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) **No** (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT & ADDRESS

William Firestone, Myersville, Md.**I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**IMMEDIATE CAUSE **Cardio-Renal-Vascular disease**

(A)

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(B)

(C)

ArteriosclerosisINTERVAL BETWEEN
ONSET AND DEATH**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.**

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While
at work

21f. HOW DID INJURY OCCUR?

Not while
at work 22. I hereby certify that I attended the deceased from **Jan 26, 1958**, to **Jan 26, 1958**, that I last saw the deceased alive on **Jan 26, 1958**, and that death occurred at **9:40 P.M.** from the causes and on the date stated above.

SIGNATURE

J. Elmer Harp

M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

*Middletown 1-27-58*23. BURIAL, CREMATION,
REMOVAL (SPECIFY)**burial**

DATE THEREOF

1/29/1958

NAME OF CEMETERY OR CREMATORI

Lutheran Cemetery

LOCATION (City, town, or county)

(State)

Myersville, Md.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

*ladhill Co., Middletown, Md.*DATE **JAN 29 '58***Elmer Harp*

RECEIVED - BY THE STATE OF SOUTH-DAKOTA

STATE OF SOUTH DAKOTA

BUREAU V. S.
RECEIVED
JAN 29 1959

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

690

CERTIFICATE OF DEATH

00679

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Thurmont	
c. LENGTH OF STAY IN 1b 50 yrs.		d. STREET ADDRESS /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eva First Catherine Sharer		4. DATE OF DEATH Month January Day 27 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1880
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Willhide	
14. MOTHER'S MAIDEN NAME Elizabeth Graham		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Anna Bentzel Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) myocardial ischemia		?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 18, 1958 , to Jan. 27, 1958 , that I last saw the deceased alive on Jan. 26, 1958 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Franklin Birely		ADDRESS (Street, city or town, state) Thurmont Md	
PHYSICIAN'S NAME (Type) Dr. M. Franklin Birely		DATE SIGNED 1/28/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-58	
22c. NAME OF CEMETERY OR CREMATORIUM United Brethren Cemetery		22d. LOCATION (City, town, or county) Thurmont, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR Jan 30 '58		24b. REGISTRAR'S SIGNATURE Allie Reich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REGISTRATION

DECEASED'S NAME JOHN W. HANNAH	SEX MALE	AGE 52	CAUSE OF DEATH HEART DISEASE
ADDRESS 1234 FAIRFIELD DR.	STATE WISCONSIN	CITY SEATTLE	ZIP CODE 98111
NAME AND ADDRESS OF DOCTOR DR. JAMES L. BROWN 1234 FAIRFIELD DR.	NAME AND ADDRESS OF FUNERAL HOME HANNAH FUNERAL HOME 1234 FAIRFIELD DR.	NAME AND ADDRESS OF CEMETERY FAIRFIELD CEMETERY 1234 FAIRFIELD DR.	NAME AND ADDRESS OF CHURCH FAIRFIELD CHURCH 1234 FAIRFIELD DR.
I declare under penalty of perjury that the information contained in this certificate is true and correct.			
BUREAU V. S.			

JAN 30 1958

DECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

660 CERTIFICATE OF DEATH

00680

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Frederick		c. LENGTH OF STAY IN 1b 51 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 512 West South Street		d. STREET ADDRESS 326 E. Church Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LEVI	Middle CALVIN	Last SHAW	4. DATE OF DEATH January 10, 1958	Month January	Day 10	Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 28, 1869	9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elijah E. Shaw		14. MOTHER'S MAIDEN NAME Elizabeth Staub		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. No	17. INFORMANT Mrs. Arie Bruchey (same as item #1)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility INTERVAL BETWEEN ONSET AND DEATH 1 yr. 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 35 E. Church Frederick, Md.	20f. (City or town) Frederick	(County) Maryland
21. I certify that I attended the deceased from JAN. 9, 1958 , to JAN 10, 1958 , that I last saw the deceased alive on JAN. 9, 1958 , and that death occurred at 10 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E. Church Frederick, Md. DATE SIGNED 1-10-58							
ACTUAL SIGNATURE Rex R. Martin	M.D.						
PHYSICIAN'S NAME (Type) Rex R. Martin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 14, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son		ADDRESS 106 E. Church Street, Frederick, Maryland		24a. REC'D BY REGISTRAR JAN 14 1958	24b. REGISTRAR'S SIGNATURE John Etchison		
VS A15 (4) 15M 9/55		DATE					

01 JUN 1988-101400 TO TWO HUNDRED TWENTY ONE ZERO ZERO ZERO

BUREAU V.

IAN 14 1958

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00681
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	c. LENGTH OF STAY IN 1b 3 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		d. STREET ADDRESS 103 East Seventh Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First FRANKLIN	Middle MARSHALL	Last INGLE SIX		
4. DATE OF DEATH January 16, 1958	Month	Doy	Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 20 June 1904		
			9. AGE (In years ^{age at death} yrs.) 53	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Silo Factory		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Osborne I. Six		14. MOTHER'S MAIDEN NAME Mamie D. Boone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 214-10-5417		17. INFORMANT Mrs. Gladys S. Sweeney (Same as item #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<i>Carcinoma of colon</i>			
(b) DUE TO <i>Intrauterine birth, longo</i>		Lifes. + 10 days			
(c) DUE TO <i>Obstruction</i>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 16</i> , 19 <i>57</i> , to <i>Jan 16</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Jan 16</i> , 19 <i>58</i> , and that death occurred at 11:50 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 228 N. Market St., Frederick, Md. DATE SIGNED 1-20-58			
ACTUAL SIGNATURE <i>B. O. Thomas</i>					
PHYSICIAN'S NAME (Type) B. O. Thomas, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-20-58		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison and Son, Frederick, Maryland		ADDRESS M. R. Etchison and Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE JAN 21 '58	
				24b. REGISTRAR'S SIGNATURE <i>A. Etchison</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN - 21 1978

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

691

CERTIFICATE OF DEATH

00682

Reg. Dist. No. 139

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN 1b 1005 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Alice	Middle West	Last Smith
4. DATE OF DEATH	Month January	Day 16	Year 19 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1883
9. AGE (In years last birthday) 74	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) West Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas H. West	14. MOTHER'S MAIDEN NAME Frances Hennen		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Records of Victor Cullen State Hospital	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degenerative heart disease INTERVAL BETWEEN ONSET AND DEATH 4 yrs.			
002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Tuberculosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 18, 1955 , to January 16, 1958 , that I last saw the deceased alive on January 15, 1958 , and that death occurred at 6:50 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE T. F. Vestal ADDRESS (Street, city or town, state) Cullen, Md. DATE SIGNED Jan. 16, 1958			
PHYSICIAN'S NAME (Type) T. F. Vestal			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/19/58	22c. NAME OF CEMETERY OR CREMATORIUM Queens Point Cemetery	22d. LOCATION (City, town, or county) Keyser, West Virginia (State)
23. FUNERAL DIRECTOR'S SIGNATURE Zuta - Lang Funeral Home. - Md.	ADDRESS Hagerstown	24a. REC'D BY REGISTRAR JAN 20 1958	24b. REGISTRAR'S SIGNATURE Alt. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

662 CERTIFICATE OF DEATH

00683
131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital		d. STREET ADDRESS 179 West All Saints Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) GRACE		First GRACE	Middle MAY	Last SNOWDEN	4. DATE OF DEATH January 9, 1958	Month Jnauary	Day 9,	Year 19 58
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH February 17, 1880	9. AGE (In years 77 day birthday) yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. MIN. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rev. W. I. Snowden, 26 W. All Saints St., Frederick, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Arteriosclerosis / Heart disease		INTERVAL BETWEEN ONSET AND DEATH 8 yrs.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North Market Street, Frederick, Maryland		(County) Frederick		(State) Maryland
21. I certify that I attended the deceased from Jan 8, 1949 , to Jan 8, 1958 , that I last saw the deceased alive on Jan 8, 1958 , and that death occurred at 9:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) North Market Street, Frederick, Maryland								
ACTUAL SIGNATURE H. F. Kline		DATE SIGNED 1/11/58						
PHYSICIAN'S NAME (Type) Dr. H. F. Kline, Sr.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 13, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR JAN 14 '58		24b. REGISTRAR'S SIGNATURE Albert Etchison		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

IAN 14 1953

RECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG221 1-21-58 et

663

CERTIFICATE OF DEATH

Reg. Dist. No. 00684

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 Da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountaintdale X (Thurmont R.D.)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle Daniel	Last Staley	4. DATE OF DEATH	Month Jan.	Day 18.	Year 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years at birthday) 77-72 yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 14. 1885				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Fredk. City		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Staley		14. MOTHER'S MAIDEN NAME Cordelia C. Shankle					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
		220-26-0570		Mrs Mamie V. Staley		Thurmont R.D. MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X		Cerebral hemorrhage				48 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Hypertensive cardiovascular disease				10 YEARS?	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Congestive myocardial failure				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 16 Jan., 1958, to 18 Jan., 1958, that I last saw the deceased alive on 18 Jan., 1958, and that death occurred at 1 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE James S. Stoner, Jr. M.D.						ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		WALKERSVILLE, Md				DATE SIGNED 20 Jan 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21. 1958		22c. NAME OF CEMETERY OR CREMATORIUM M.P. Cemetery		22d. LOCATION (City, town, or county) Lewistown. Fredk. Co. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont MD		24a. REC'D BY REGISTRAR DATE JAN 22 '58		24b. REGISTRAR'S SIGNATURE A. L. Smith	

CERTIFICATE OF DEATH

REG-270X

STATE
MAN

BUREAU V. S.

JAN 22 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
692 CERTIFICATE OF DEATH

00685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville		c. LENGTH OF STAY IN lb 28 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WILBUR	Middle EARL	Lost	4. DATE OF DEATH January 19	Month	Day	Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 7, 1897	9. AGE (in years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Garageman		10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John F. Summers				14. MOTHER'S MAIDEN NAME Laura Poffinberger		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-32-5414		17. INFORMANT Mrs. Nancy S. Summers, Myersville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		<i>Coronary Arteries chronic Heart Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Obesity, moderate</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 998 Pictures Dr.		20f. (City or town) Myersville		(County) Fred. C. Md.
21. I certify that I attended the deceased from 9/11/57 , 19 58 , to 1/19 , 19 58 , that I last saw the deceased alive on 1/19 , 19 58 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 7 Maryland, Md.		DATE SIGNED 1/22/58		
ACTUAL SIGNATURE <i>Dalton M. Welty</i>		PHYSICIAN'S NAME (Type) DALTON M. WELTY						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 22, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Lutheran		22d. LOCATION (City, town, or county) Myersville, Fred. C. Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul F. Bittle</i>		ADDRESS Myersville, Md.		24a. REC'D BY REGISTRAR JAN 22 '58		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>		

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01-390191188-HYDRA190 TEAM12A190 STATE CHA/PRA/M

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

693

CERTIFICATE OF DEATH

Reg. Dist. No.

00686

1. PLACE OF DEATH a. COUNTY Frederick			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#4		c. LENGTH OF STAY IN 1b 44 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frederick-Rural-R.D.#4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mountville Road			d. STREET ADDRESS Mountville Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First CLAUDE	Middle ERVIN	Last SWARTZ	4. DATE OF DEATH January 28, 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1895	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) West Virginia			
13. FATHER'S NAME John Talbott			14. MOTHER'S MAIDEN NAME Rosie Swartz				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 162.1		16. SOCIAL SECURITY NO. 220-05-6316		17. INFORMANT Swartz Address Mrs. Alice S. Swartz, Frederick, R.D.#4, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Phlebitis			INTERVAL BETWEEN ONSET AND DEATH 3 mo				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Brechogenic Carcinoma			5 yrs				
DUE TO (c) Left Lung							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 260x Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	Day <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Jefferson, Maryland	(County) Jefferson	(State) Maryland
21. I certify that I attended the deceased from Jan. 28, 1958 to Jan. 28, 1958 , that I last saw the deceased alive on Jan. 28, 1958 , and that death occurred at 10:30 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Jefferson, Maryland DATE SIGNED 1/29/1958							
ACTUAL SIGNATURE A. T. Brice M.D.							
PHYSICIAN'S NAME (Type) Dr. A. T. Brice							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 31, 1958	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Luthern Cem.		22d. LOCATION (City, town, or county) Jefferson, Maryland			(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland				ADDRESS M. R. Etchison & Son, Frederick, Maryland	24a. REC'D BY REGISTRAR FEB 3 '58	24b. REGISTRAR'S SIGNATURE Alvin	

31 ФЕВРАЛЯ-17 МАРТА 2018 ГОДА ПРИЧАСТЬ СТАРЫХ УЧИЛИЩ

RECEIVED **BUREAU Y**
FEB 3 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00687

664

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 1 Week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mount Airy-Rural RD#1	
3. NAME OF DECEASED (Type or print) First ULYSSES Middle GRANT Lost TOBERY		d. STREET ADDRESS McKaig	
4. DATE OF DEATH January 29, 1958		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 16 Aug 1875
8. AGE (In years from birthday) 82 yrs.		9. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Fertilizer Plant	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William H. Tobery		14. MOTHER'S MAIDEN NAME Hester Ann (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-5003	
17. INFORMANT Mrs. Mary E. Droneburg (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelo nephritis 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH At Least 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterio sclerosis, general and cardiac		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____	(County) _____	(State) _____	
21. I certify that I attended the deceased from 11/13, 1957, to 1/29, 1958, that I last saw the deceased alive on 3/29, 1958, and that death occurred at 1:40P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) New Market, Maryland			
ACTUAL SIGNATURE Ralph L. Michels, M.D.	DATE SIGNED 1-30-58		
PHYSICIAN'S NAME (Type) Ralph L. Michels, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-1-58	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland	ADDRESS M. R. Etchison & Son, Frederick, Maryland	24a. REC'D BY REGISTRAR DATE FEB 3 '58	24b. REGISTRAR'S SIGNATURE Alfred Etchison

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CERTIFICATE OF DEATH

1952

12

DECEASED

1952-111

BUREAU V.

1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00688

665

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN lb <i>11 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Thurmont</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp</i>		d. STREET ADDRESS <i>RFD 1</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First <i>David</i>	Middle <i>wayne</i>	Last <i>Warner</i>	4. DATE OF DEATH <i>July 6 1958</i>						
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>17 March 54</i>	9. AGE (In years last birthday) yrs. <i>3</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	12. Day <i>6</i>	Year <i>1958</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>Clarence W. Warner</i>			14. MOTHER'S MAIDEN NAME <i>Mary Hartz</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Father</i>	Address <i>Thurmont RFD 1</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CHRONIC GLOMERULONEPHRITIS</i>									INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
592 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b)								
		DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Frederick</i>	(County) <i>Frederick</i>	(State) <i>MARYLAND</i>				
21. I certify that I attended the deceased from <i>24 Dec 1957</i> to <i>6 January 1958</i> , that I last saw the deceased alive on <i>6 Jan 1958</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above.									ADDRESS (Street, city or town, state) <i>220 IV Market St.</i>	DATE SIGNED <i>7 Jan 58</i>
ACTUAL SIGNATURE <i>A. M. Powell Jr. M.D.</i>										
PHYSICIAN'S NAME (Type)		<i>A. M. Powell Jr. M.D. Frederick, Md.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF <i>Jan. 9, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Olivet Cemetery</i>	22d. LOCATION (City, town, or county) <i>FREDERICK, MARYLAND</i>						
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. E. DAILEY & SON.</i>		ADDRESS <i>FREDERICK, Md.</i>	24a. REC'D BY REGISTRAR <i>JAN 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Debra Smith</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

666

CERTIFICATE OF DEATH

00689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 55 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 424 North Market Street		d. STREET ADDRESS 424 N. Market Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) T. Arnold		First	Middle	Last	4. DATE OF DEATH January	Month	Doy	Year		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		B. DATE OF BIRTH August 26, 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Job Foreman		10b. KIND OF BUSINESS OR INDUSTRY Printing Office		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Thomas P. Whitmore		14. MOTHER'S MAIDEN NAME Mary Carr								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 211-16-3110		17. INFORMANT Elwood T. Whitmore		Address Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Chronic myocarditis (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 7 North Market Street		(County) Frederick	(State) Maryland	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Jan 14 , 1958, and that death occurred at 11:05 AM , from the causes and on the date stated above. ACTUAL SIGNATURE H. F. Kline		ADDRESS (Street, city or town, state) 7 North Market Street, Frederick, Maryland		DATE SIGNED Jan 14, 1958						
22a. FUNERAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-17 -1958		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick				
23. FUNERAL DIRECTOR'S SIGNATURE H. F. Kline		ADDRESS 8 East Patrick St.		24a. REC'D BY REGISTRAR JAN 17 '58		24b. REGISTRAR'S SIGNATURE DeLoach				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRUNAU V.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00690

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CERTIFICATE OF DEATH

Reg. Dist. No.

131

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville-Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville-Rural					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broad Run Road		d. STREET ADDRESS Broad Run Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RIDGELY		First ABRAHAM	Middle 	Last WILLARD	4. DATE OF DEATH January 15, 1958	Month January	Day 15	Year 1958	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH September 23, 1880	9. AGE (In years from birthday) 77 yrs.	IF UNDER 1 YEAR 77	IF UNDER 24 HRS. Months 77	Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Tillman A. Willard		14. MOTHER'S MAIDEN NAME Laura House							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-38-9894		17. INFORMANT Mr. Arthur K. Willard, Same as item #2		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Coronary Occlusion Sudden						INTERVAL BETWEEN ONSET AND DEATH Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Middletown	(County) Maryland	(State) Maryland	
21. I certify that I attended the deceased from Jan 15, 1958 , to Jan 15, 1958 , that I last saw the deceased alive on Jan 15, 1958 , and that death occurred at 9:30 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. Middletown, Maryland		DATE SIGNED 1/17/58			
ACTUAL SIGNATURE <i>Elmer Harp</i>									
PHYSICIAN'S NAME (Type) Drl Elmer J. Harp									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 18, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Reformed Cemetery		22d. LOCATION (City, town, or county) Middletown, Maryland		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Jan 20 '58		24b. REGISTRAR'S SIGNATURE <i>Reed</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH—BULWIGER 18

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM J. BROWN	50	M	CHRONIC CARDIOPNEUMONIA
ADDRESS	STREET	CITY	STATE
100 WISCONSIN AVENUE	100	MILWAUKEE	WISCONSIN
NAME AND ADDRESS OF DOCTOR	STREET	CITY	STATE
DR. JAMES M. HANNAH	100	MILWAUKEE	WISCONSIN
NAME AND ADDRESS OF FUNERAL DIRECTOR	STREET	CITY	STATE
WILLIAM J. BROWN	100	MILWAUKEE	WISCONSIN
NAME AND ADDRESS OF PERSON FILING CERTIFICATE	STREET	CITY	STATE
WILLIAM J. BROWN	100	MILWAUKEE	WISCONSIN
DATE OF DEATH	TIME	CAUSE OF DEATH	DEATH CERTIFIED
APRIL 20, 1958	10:00 A.M.	CHRONIC CARDIOPNEUMONIA	BY DR. JAMES M. HANNAH
NAME OF PERSON SIGNING	STREET	CITY	STATE
WILLIAM J. BROWN	100	MILWAUKEE	WISCONSIN
DATE	TIME	REASON FOR SIGNING	REMARKS
APRIL 20, 1958	10:00 A.M.	AS FATHER	

BUREAU V. S.

IAN 20 1958

K-671-V-E0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

695

CERTIFICATE OF DEATH

00691
139

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen		c. LENGTH OF STAY IN lb 877 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 V O I - 4 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Victor Cullen State Hospital				d. STREET ADDRESS 2211 N. Calvert St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle Luther	Last Wright	4. DATE OF DEATH	Month January	Day 24	Year 19 58
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 6, 1908	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Housing		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Wright				14. MOTHER'S MAIDEN NAME Fannie Bunn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 242-07-1172		17. INFORMANT Records of Victor Cullen State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002 X DUE TO Far advanced pulmonary tuberculosis							
INTERVAL BETWEEN ONSET AND DEATH 5 yrs.							
Conditions, if any, which gave rise to immediate cause (a), stating the under- } lying cause lost. } (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 31, 1955 , to January 24, 1958 , that I last saw the deceased alive on January 23, 1958 , and that death occurred at 6:00 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cullen, Md. DATE SIGNED January 24, 1958							
ACTUAL SIGNATURE T. F. Vestal		M.D.					
PHYSICIAN'S NAME (Type) T. F. Vestal, M.D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-58		22c. NAME OF CEMETERY OR CREMATORIUM Columbia Gardens Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Cramer		ADDRESS Thurmont, Md.		24a. REC'D BY REGISTRAR JAN 28 '58		24b. REGISTRAR'S SIGNATURE R. C. C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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BUREAU V. S.

JAN 02 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
696 CERTIFICATE OF DEATH

Reg. Dist. No. 00692
131

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown-Rural RD#1			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adamstown-Rural RD#1					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Flint Hill			d. STREET ADDRESS Flint Hill e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First GRACE	Middle IRENE	Last YINGLING	4. DATE OF DEATH	Month January	Day 11,	Year 1958
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 42 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility Worker			10b. KIND OF BUSINESS OR INDUSTRY Tailoring Company	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Lewis E. Horman			14. MOTHER'S MAIDEN NAME Hattie E. Cutsail					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.	17. INFORMANT	Address			
			Vernon Windsor Yingling (Same as item #1)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0 Carcinoma, right ovary INTERVAL BETWEEN ONSET AND DEATH 2 years								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) (d) Multiple abdominal metastases 1½ years								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1955, to Jan. 11, 1958, that I last saw the deceased alive on Jan. 10, 1958, and that death occurred at 3:15 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Bernard O. Thomas, Jr., M.D. ADDRESS (Street, city or town, state) 228 N. Market St., Frederick, Md. DATE SIGNED 1-13-58 PHYSICIAN'S NAME (Type) Physician's Name (Type) Frederick, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 1-15-58			22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland			ADDRESS			24a. REC'D BY REGISTRAR JAN 14 '58		
						24b. REGISTRAR'S SIGNATURE Abigail Etchison		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

302

PLATE NO. 3000

DEATH DATE

STATE

CITY

COUNTY

NAME

BUREAU N.Y.

JAN 14 1968

RECEIVED